The Health Insurance Marketplace: Know Your Rights

You have certain rights when you enroll in a health plan in the Marketplace. These rights include:

- Getting easy-to-understand information about what your plan covers, what services cost you out-of-pocket, what drugs it covers, and what providers are in its network
- Getting coverage for emergency services
- Getting coverage for a prescription drug that's not normally covered by your plan
- Appealing a health plan's decision not to pay a claim

Getting plan information

Summary of Benefits and Coverage

You have the right to get an easy-to-understand summary about a health plan's benefits and coverage.

Insurance companies must give you:

- A short, plain-language Summary of Benefits and Coverage, which outlines what the plan covers and what those services would cost you out-of-pocket
- A Uniform Glossary of certain terms used in health coverage and medical care

All individual plans must use the same standard form to help you compare plans. The Summary of Benefits and Coverage also includes details, called coverage examples, which allow you to see examples of what the plan would cover in 2 common medical situations: diabetes care and childbirth.

You'll find a link to each plan's Summary of Benefits and Coverage in the Marketplace when you're comparing plans.

When can I get a Summary of Benefits and Coverage?

You have the right to get this summary when shopping for or enrolling in coverage.

The Summary of Benefits and Coverage is available for every plan in the Marketplace. You'll find a link to it on each plan page when you enroll through the website.

You can also ask for a copy from your insurance company at any time. All health plans must provide the Summary of Benefits and Coverage to you at important points in the enrollment process, like when you apply for or renew your policy. You can also ask for a copy of the Uniform Glossary to help you understand words used in health coverage and medical care.

Can I get a Summary of Benefits and Coverage in another language?

If you don't speak English, you may be able to get the Summary of Benefits and Coverage and Uniform Glossary in your native language upon request.

Provider Directory

A health plan's provider directory, also called a provider network directory, lists the network of doctors, hospitals, and other health care providers that contract with that health plan to give medical care to its enrollees. If you use a doctor or facility that's not in your plan's network, you may have to pay more for the services you get.

When you are shopping for a health plan, you may want to use the provider network directory to search for a plan network that includes your current doctor. At any point in time, you can also use the provider network directory on your health plan's website to find a new doctor.

Every plan in the Marketplace must have a provider network directory link on its website – and the directory should have the most current listing of network providers to help you with your enrollment decisions. **HealthCare.gov** provides direct links to provider directories for every plan in the Marketplace, so you can easily tell where you can receive services.

Drug Information

When you are shopping for a health plan, you may also want to look for a health plan that covers any prescription drugs you currently use.

HealthCare.gov provides web links to lists of covered drugs for all Marketplace plans, so you can find out what prescriptions different plans cover. Your Summary of Benefits and Coverage will include a web link on how you can get more information about your prescription drug coverage.

Coverage of emergency services

Every plan in the Marketplace (other than a dental plan) must cover hospital emergency services. You can get emergency services:

- Whether or not you go to a network provider for the services you get.
- Without prior authorization (even if the service is provided out-of-network).

What if I get emergency care out-of-network?

Your plan must cover out-of-network emergency care without:

- Limiting coverage in ways that are more restrictive than in-network limits.
- Charging you a copayment or coinsurance that's more than the cost for in-network care.

You may have to pay other costs, such as a deductible, if it applies to your out-of-network benefits.

Can my health plan have conditions of coverage for emergency care?

Generally, your plan must cover emergency services regardless of any other term or condition of coverage. If the particular service you get isn't covered by your plan, you may have to pay the total cost of that service if you don't have other coverage.

Getting coverage for a prescription drug that's not covered by your plan

Every health plan in the Marketplace must have a prescription drug exceptions process that allows you to request coverage of a prescribed drug that's not covered by your health plan. This process is different than appealing the denial of a drug that is covered. The information below describes the recommended process, but the details of your plan's process may be different. Contact your plan for detailed information about its prescription drug exceptions process.

How do I get an exception for a non-covered drug prescribed by my doctor?

To request a drug through the exceptions process, your doctor would generally confirm to your plan (orally or in writing) that the non-covered drug is clinically appropriate for your medical condition based on factors such as one or more of the following:

- All other drugs covered by the plan either haven't been or won't be as effective as the drug you're requesting
- Any alternative drug covered by your plan has caused or is likely to cause side effects that may be harmful to you
- If there's a limit on the number of doses you're allowed: That allowed dosage hasn't worked for your condition, or
- The drug will likely not work for you based on your physical or mental makeup. For example, based on your body weight, you may need to take more doses than what's allowed by your plan.

Can I get the non-covered drug during the exceptions process?

While you're in the exceptions process, your plan may give you access to the requested drug until a decision is made.

What happens if I get the exception?

If you get the exception:

- You can generally get the non-covered drug for a certain period of time. Your health plan will generally treat the drug as covered and may charge you the copayment that applies to the most expensive drug tier on the formulary (for example, a non-preferred brand drug).

Appealing a health plan decision

If your health insurance company doesn't pay a claim that you filed, you have the right to appeal the decision and have it reviewed by an independent third party.

Your insurance company must first notify you in writing within a set amount of time (based on the type of claim you filed) to explain why you were denied. And then they have to let you know how you can appeal their decisions.

If the timeline for the standard appeal process would seriously put your life at risk, or risk your ability to fully function, you can also file an appeal that would get you a quicker decision. If you meet the standards for an expedited external review, the final decision about your appeal must come as quickly as your medical condition requires, no later than 72 hours after your request for external review is received.

How the appeals process works:

After your health insurance company denies your claim, you can start the appeals process. Any instructions specific to your health insurance company will be listed on the information they sent you when they denied your claim.

There are 2 types of appeals:

1. An **internal appeal** (an appeal directly to your insurance company)
2. An **external appeal** (an appeal decided by an independent third party)

You can file your internal appeal and external review within the timeframes below.

Internal appeal

If you decide to ask for an internal appeal, you must file the internal appeal within 180 days (about 6 months) of getting notice that your claim was denied. To file an internal appeal you must:

- Complete all forms required by your health insurance company or write to your insurance company with your name, claim number, and health insurance ID number.
- Submit any other information that you want the insurance company to consider when evaluating your appeal, such as a letter from the doctor.

Your insurance company must then provide you with a written decision at the end of the internal appeals process. If your insurance company still denies you the service or payment for a service, you can ask for an external review. Find out how to ask for an external review on the insurance company's final decision letter.

External appeal

If you decide to ask for an external review, you must file a written request within 4 months in most states (60 days in some states) of the date your insurance company sent you the final decision to deny your claim. The notice sent to you by your health insurance company should tell you the timeframe in which you must make your request.

You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an external review on your behalf.

- The information on the final denial of the internal appeal by your health plan will give you the contact information for the independent third party that will handle your external review.
- The external reviewer will issue a final decision. An external review either keeps your insurance company's decision, or decides in your favor. **Your insurance company is required by law to accept the external reviewer's decision.** Standard external reviews are decided as soon as possible — no later than 45 days in most states (60 days in some states) after the request was received. An expedited external review process is also available if your claim meets certain standards.

Getting help with your appeal

Whether you're appealing a Marketplace eligibility decision or a health plan coverage decision, you don't have to do it alone. There are many resources available to help you with your appeal.

- You can call the Health Insurance Marketplace Call Center at **1-800-318-2596** 24 hours a day, 7 days a week. TTY users should call **1-855-889-4325**. Visit **HealthCare.gov/can-i-appeal-a-marketplace-decision/** for information on eligibility appeals. You can also find other helpful information about appeals on **HealthCare.gov**.
- Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations. Visit **LocalHelp.HealthCare.gov** to find help in your area.
- If you don't speak English, you can get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call **1-800-318-2596.**
- You can appoint an authorized representative to help you. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. This can be done several ways, depending on the type of appeal you're filing. To get the forms you'll need to appoint a representative, visit **HealthCare.gov.**

Other rights and protections

Depending on where you live, your state may offer other rights and protections. Contact your local Department of Insurance for more information.